

MARGIN RESERVED FOR BINDING

V. S. No. 08
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

22458 253

1 PLACE OF DEATH
County St. Louis State Missouri Registered No. _____
Township Paradise or Village _____ or _____
City Jefferson Barracks, Mo. No. U.S.V. Hospital Jefferson Bks., Mo. St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harold L. Difani
(a) Residence. No. St. Marys, Mo. St. _____ Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>		
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____				
6 DATE OF BIRTH (month, day, and year) <u>Dec. 13, 1896</u>				
7 AGE <u>30</u>	Years	Months <u>6</u>	Days <u>21</u>	If LESS than 1 day, --- hrs. or --- min.
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Shoemaker</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Unknown</u> (c) Name of employer				

9 BIRTHPLACE (city or town) <u>St. Marys, Mo.</u> (State or country)				
PARENTS	10 NAME OF FATHER <u>Lawrence J. Difani</u>			
	11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) <u>Missouri</u>			
	12 MAIDEN NAME OF MOTHER <u>Emma Solf</u>			
	13 BIRTHPLACE OF MOTHER (city or town) <u>Union</u> (State or country) <u>Mo.</u>			

14 Informant <u>H. A. Scott</u> (Address) <u>Med. Officer, USVB</u>
15 Filed <u>July 4</u> 19 <u>27</u> <u>USV Hosp., Jefferson Bks., Mo.</u> <u>L. C. Obrock</u> REGISTRAR

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH (month, day, and year) <u>July 3</u> 19 <u>27</u>	
17 I HEREBY CERTIFY, That I attended deceased from <u>June 21, 1927</u> , to <u>July 3, 1927</u> that I last saw him alive on <u>July 3, 1927</u> , and that death occurred, on the date stated above, at <u>1:00 a. m.</u> The CAUSE OF DEATH* was as follows: <u>Bronchial pneumonia</u>	
<u>1074/00-a</u> <u>874</u> (duration) <u>48</u> hours yrs. mos. ds.	
CONTRIBUTORY <u>multiple neuritis</u> (SECONDARY) <u>five three weeks</u> (duration) yrs. mos. ds.	
18 Where was disease contracted <u>Unknown</u> If not at place of death? _____	
Did an operation precede death? <u>No</u> Date of _____	
Was there an autopsy? <u>No</u> Findings _____	
What test confirmed diagnosis? <u>Physical & Laboratory</u> (Signed) <u>H. W. Barker</u> , M. D., 19 (Address) <u>Chief Medical Officer, USVB</u> <u>Medical Officer in Charge</u>	
* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)	

19 PLACE OF BURIAL, CREMATION, OR REMOVAL <u>St Marys Mo</u>	DATE OF BURIAL <u>July 5 1927</u>
20 UNDERTAKER <u>Chippmester & Co</u>	ADDRESS <u>7514 So Broadway</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association)

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc.; without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation); using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

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ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.